control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere providers should reference Section 21 of these Principles.

25 UPPER PAYMENT LIMITS

25.1 Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payments in 42 C.F.R. §447.272, using Medicare principles of reimbursement.

25.2 If the Division of Audit projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

25.3 In computing the projections that Medicaid payments in the aggregate are within the Medicare Upper Limit, any facility exceeding 112% of the State mean allowable routine service costs, may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement including any exceptions as stated in 42 CFR 413.30(f). This information may be requested within 30 days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

25.4 Facility Rate Limitations if Aggregate Limit is Exceeded. If the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected Medicaid payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

26 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

27 RECORD KEEPING AND RETENTION OF RECORDS

27.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department

of Health and Human Services, and the authorized representatives of either agency.

27.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

27.3 The provider shall maintain all such records for at least three years from the date of filing, or the date upon the which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

27.4 When the Department of Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty days the Department intends to reduce payments to a 90% level of reimbursement as set forth is Section 152 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

30 FINANCIAL REPORTING

31 MASTER FILE

The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the Maine Medicaid program:

31.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider,

31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21,

31.3 Plant layout if available,

31.4 Terms of capital stock and bond issues,

31.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements,

31.6 Schedules for amortization of long-term debt and depreciation of plant assets,

31.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider.

31.8 Related party information on affiliations, and contractual arrangements,

31.9 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.

If any of the items listed in Subsections 31.1 - 31.9 are not submitted in a timely fashion the nursing facility may receive a deficiency per diem. The Department may impose the deficiency per diem rate described in Section 152 of these Principles.

32 UNIFORM COST REPORTS

32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes monies to the Department of Human Services, a check equal to 50% of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to

offset the current payments to the facility until the entire amount is collected from the provider.

32.2 Forms. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Human Services.

32.3 Each long-term care facility in Maine must submit an annual cost report within three months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the long-term care facility can submit an additional copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Director of the Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.

32.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than the facility, the preparer should also sign the report.

32.5 The original and one copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.

32.6 The following supporting documentation is required to be submitted with the cost report:

32.61 Financial statements,

32.62 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),

32.63 Reconciliation of the financial statements to the cost report.

32.7 A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division of Audit requires in order to carry out its function. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 152 of these Principles.

32.8 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

33 ADEQUACY AND TIMELINESS OF FILING

33.1 The cost report and financial statements for each facility shall be filed not later than three months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be madke at the deficiency rate of 90%.

33.2 The Division of Audit may reject any filing which does not comply with these regulations. In such case, the report shall be deemed not filed, until refiled and in compliance.

33.3 Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

33.31 All requests for extension of time to file a cost report must be in writing, and must be received by the Division of Audit 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division of Audit will receive the report.

33.32 The Division of Audit will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director of the Division of Audits sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal basis for the delay or an intervening action beyond the providers control. The following are not considered "good cause"; ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

34 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

34.1 Uniform Desk Review

34.11 The Division of Audit shall perform a uniform desk review on each cost report submitted.

34.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Division of audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

34.13 Uniform desk reviews shall be completed within 180 days after receipt of an acceptable cost report filing only after one full year under these principles, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

34.14 Unless the Division of Audit intends to schedule an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

34.2 On-site Audit

34.21 The Division of Audit will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems.

34.22 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

34.23 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audits requirements.

34.24 Upon completion of an audit, the Division of Audit shall review its draft findings and adjustments with the provider and issue a written summary of such findings.

35 SETTLEMENT OF COST REPORTS

35.1 A cost report is settled if there is no request for reconsideration of the Division of Audits findings or, if such request for reconsideration was made and the Division of Audit has issued a final audit.

35.2 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audits decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.

35.3 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision otherwise final. Such action may only be taken:

35.31 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.5; and,

35.32 When the reopening may have a material effect (more than one percent) on the provider's Medicaid rate payments.

35.4 A correction is a revision (adjustment) in the Division of Audits determination, otherwise final, which is made after a proper re-opening. A correction may be made by the Division, or the provider may be required to file an amended cost report.

35.5 A determination or decision may only be re-opened within three years from the date of notice containing the Division of Audits determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.

35.6 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound ~~by~~ by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

37 REIMBURSEMENT METHOD

37.1 Principle. Nursing care facilities will be reimbursed for services provided to recipients under the program based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

37.2 Nursing facilities costs will be periodically rebased by the Department of Human Services when the Commissioner of the Department of Human Services determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs as established in the Omnibus Reconciliation Act of 1987.

40 COST COMPONENTS

40.1 In the prospective system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictate which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following four cost categories:

40.11 Direct Patient Care Costs,
40.12 Indirect Patient Care Costs,
40.13 Routine Costs, and
40.14 Fixed Costs.

Sections 41-49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

41 Direct Patient Care Cost Component

41.1 Direct patient care costs include:

41.11 registered nurses,
41.12 licensed practical nurses,
41.13 nurse aides,
41.14 patient activities personnel,
41.15 ward clerks,
41.16 payroll tax,
41.17 fringe benefits for the positions listed above,
41.18 The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of direct patient care costs and shall be included in the indirect patient care cost component.

41.2 Allowable costs for the Direct Patient Care component of the rate shall include:

41.21 Direct Patient Care Cost The base year costs for direct patient care costs shall be the lower of actual or approved direct patient care costs incurred by the facility in the fiscal year beginning in 1990.

41.21(a) The base year allowable costs for nursing facilities that have been approved for additional direct patient care staff since the facilities fiscal year which began in 1990 will be the approved direct patient care staff costs.

41.21(b) For nursing facilities that have been approved for additional direct patient care staff since the facilities fiscal year which began in 1990, the additional approved direct patient care staffing will be added to the interim direct patient care component as a supplemental allowance. The supplemental allowance will be added to the direct

patient care component after the first audit has been conducted, if it is determined that these hours have been used for one full operating year. Hours and costs associated with the supplemental allowance will be excluded from the calculation of cost savings.

41.22 The Department will calculate each facility's base year wage, salary and benefit costs by establishing an average hourly wage per category of staff and multiplying it by the lesser of the actual number of hours provided during the relevant time period or the number of hours approved by the Division of Licensing and Certification for that time period. In order to provide an equitable base for all facilities, the Department will determine the average hourly wage and the number of hours provided for the fiscal year beginning in 1990. This determination will exclude any compensation that does not reasonably represent annual, ongoing wage and salary expenses.

41.23 Contractual labor will be included in the calculation of the number of hours of labor provided in the base year. However, the actual cost of providing contractual labor will be excluded from the average hourly wage calculation. Costs for contractual labor in the base year will be an allowable cost up to the average hourly wage paid for similar staff within the nursing facility.

41.24 The Department will not include any expenditures related to employee wages, salaries and benefits for hours in excess of those hours approved by the Division of Licensure and Certification in the calculation of each facility's base year.

42 INDIRECT PATIENT CARE COST COMPONENT

42.1 Allowable cost for the Indirect Patient Care Cost component shall include reasonable costs associated with expenses related to indirect patient care. Each nursing facility's upper limit for indirect patient care costs is computed as the median plus 15% of the indirect patient care costs per patient day for nursing facilities in the appropriate peer group. See Section 80.4 for the computation. Indirect patient care costs include:

42.11 food, vitamins and food supplements,
42.12 director of nursing, and fringe benefits,
42.13 social services, and fringe benefits,
42.14 medical supplies, equipment and drugs which are supplied as part of the regular rate of reimbursement. See Appendix B which is abstracted from Maine Medical Assistance Manual Appendix #8.

42.11.1 Inventory items shall include, but are not limited to: medical spplies and food.

42.2 These types of consultative services will be considered as part of the allowable indirect patient care costs and be built into the base year indirect patient care cost components subject to the limitations outlined in subsections 42.211 - 42.251:

42.21 Pharmacist Consultants
42.22 Dietary Consultants
42.23 Medical Directors
42.24 Social Worker Consultants

42.211 **Pharmacist Consultants.** Pharmacist consultants fees paid directly by the facility in the base year, will be included in the indirect patient care cost component for inclusion in the facilities per diem rate. . In addition to any pharmacist consultant fees included in the base year rate, up to $2.50 per month per resident shall be allowed for drug regimen review.

42.221 **Dietary Consultants.** Dietary Consultants professionally qualified, may be employed by the facility or by the Department. The allowable amounts paid by the nursing facility to Dietary Consultants in the base year when reasonable and non-duplicative of current staffing patterns will be built into the base year indirect patient care cost component for inclusion in the facilities per diem computation.

42.231 **Medical Director.** The base year costs of a Medical Director, who is responsible for implementation of resident care in the facility, is an allowable cost. The base year allowable cost will be established at $1,200. is limited for up to twelve (12) annualty meetings at one hundred dollars ($100) per meeting.

42.241 **Social Worker Consultant.** The base year consultation fees for a qualified social worker is an allowable cost for visits up to a maximum of four (4) hours quarterly, at twelve dollars ($12) per hour. The allowable amounts paid by the nursing facility in the base year will be included in the indirect patient care cost component. or tThe facility may request the Department to provide consultation in accordance with Title 32, §7053-A.4 of the Maine State Statue. The allowable cost in the base year shall be pro-rated on the number of Title XIX nursing patients.